Appendix 2
HCFA 1500 Claim Form Completion Instructions for Chiropractic Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when asked to do so. All elements are required unless "not required" is specified.

Wisconsin Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before rendering services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "P" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's ID Number
Enter the recipient's 10-digit Wisconsin Medicaid identification number from the current identification card. Do not enter any other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be entered.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid, unless the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook.

- Leave this element blank when the provider has not billed health insurance because the "Other Coverage" on the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook, or the recipient's identification card indicates "DEN" only.

- When "Other Coverage" on the recipient's identification card indicates HPP, BLU, WPS, CHA, DEN, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the provider handbook, indicate one of the following codes in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	***Description***
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or

the insured is indicated on the claim.

OI-D DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.

OI-Y YES, card indicates health insurance but it was not billed for reasons including, but not limited to:

- recipient denies coverage or will not cooperate;
- the provider knows the service in question is noncovered by the carrier.
- health insurance carrier failed to respond to initial and follow-up claim; or
- benefits not assignable or cannot get an assignment.

- When "Other Coverage" on the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable:

Code	*Description*
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill for services which are included in the capitation amount.

Element 10 - Is Patient's Condition Related To (not required)

Element 11 - Insured's Policy, Group or FECA Number
The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing to Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare-certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's identification card indicates no Medicare coverage, leave this element blank.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefits (EOMB) to the claim and leave this element blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the provider handbook for more information about submitting claims for dual entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient has had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - ID Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, providers must describe the procedure. If element 19 does not provide sufficient space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

Element 20 - Outside Lab
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab.

Element 21 - Diagnosis or Nature of Illness or Injury
Enter an allowable diagnosis code. Refer to Appendix 3 of this handbook for allowable chiropractic diagnosis codes.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "FROM" field.

- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "FROM" field, and subsequent dates of service in the "TO" field by listing *only* the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.

- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code. Refer to Appendix 4 of this handbook for list of allowable type of service codes.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. Refer to Appendix 5 of this handbook for a list of Wisconsin Medicaid-allowable procedure codes for chiropractic services.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line item.

Element 24g - Days or Units
Enter the total number of services billed for each line item. Indicate a decimal only when a fraction of a whole unit is billed.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if *both* HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the provider handbook for information on recipient spenddown.

Any other information entered in this element may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
*Optiona*l - a provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent's Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is enter in element 29, enter "OI-P" in element 9.)

Element 30 - Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or the authorized representative must sign in element 31. Also enter the month, day, and year the form is signed (in MM/DD/YY format).

> ***Note:*** This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit provider number.